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Workplace alcohol and other drug testing

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- VAADA supports safe workplaces, there is however a lack of evidence as to the widespread effectiveness of workplace drug testing;
- Targeted programs in some workplaces may be of benefit where there is a high risk of severe harm from alcohol and other drug use in some occupational groupings;
- It is important for government to establish a framework detailing minimum standards to ensure consistency and fairness through consultation with employers and employee groups.
- VAADA supports the evolution of evidence based strategies, hence the use of pilots and evaluation strategies are a key factor.

Key Issues

Key considerations regarding alcohol and other drug (AOD) testing in the workplace are as follows:

1. Most AOD workplace testing methods do not detect impairment;
2. There is a need to build a stronger evidence base pertaining to the efficacy of AOD workplace testing in preventing harms, creating positive health and business outcomes;
3. Currently, Australia does not have binding regulations or legislation providing standards for AOD testing. A binding set of standards must be developed if AOD workplace testing is to be expanded;
4. The aims of AOD testing in the workplace must be clearly articulated;
5. There are a wide range of logistical concerns which must be addressed, including but not limited to cost, privacy and how to respond appropriately in the event of a positive result;
6. If AOD workplace testing is expanded, it should be an element of a suite a strategies to deal with workplace hazards and harms related to AOD use;
7. There are a range of other harmful factors commonly occurring in workplaces which are not related to AOD use such as poor workplace conditions or insufficient training which should not be neglected through an emphasis on AOD testing in the workplace; and
8. Workplaces which elect to implement AOD testing should involve all stakeholders (including employee representatives) in policy development process from conception to evaluation.

Workplace drug testing is impeded by a range of logistical challenges with cost implications. If these logistical considerations are not carefully managed, potentially harmful outcomes such as diversion to less detectable (yet potentially more harmful) substances and fractured relations between employers and employees may ensue. Such schemes should not be used as an adjunct tool to Human Resources management. A failure to follow such an approach could lead to unintended consequences for the workplace.

Introduction

The harms associated with AOD use are significant and present a wide range of challenges to the Victorian community in a number of contexts which include work settings.

Although it varies between industries, AOD use at work in Australia is fairly low, with alcohol typically having higher usage rates than other drugs (Pidd, Roche, Abery and Wilson 2011:23). Although there are limitations in the evidence, there are some indications that AOD use has only a limited 'direct causal role' on workplace safety and productivity. Research indicates those deemed problem drinkers are 2.7 times more likely to have 'injury related absences' compared to the general workforce (Pidd et al:24). Further confounding the evidence is the fact that light drinkers are less likely than both heavy and non-drinkers to report a workplace injury (Pidd et al:25). Further studies have highlighted that there is a relationship between AOD use and workplace injury, however this relationship is less significant than the impact of 'physical hazards and workload' on workplace injury (Pidd et al:27). With this in mind and combined with the limitations in evidence, it is important to view workplace related risks and harms as emerging from a broad spectrum of causes, and thus an emphasis on AOD testing as a panacea to these harms may be misleading.

AOD testing is at best a deterrence tool and, with the exception of breath testing, does not detect impairment, only that a specific substance is present in an individual, and that it may or may not have been there for some time, and may or may not be causing impairment. The deterrence factors relate to employees being under the apprehension that they may be drug tested and thus should abstain from taking any substances or transition to a less detectable substance (which may be more harmful) out of fear of the ramifications of a positive AOD test. It does not detect long term harms or dependence, and thus does not provide a strong basis from which an assessment can be made to ascertain treatment needs.

What is AOD testing?

AOD testing can be conducted via a number of means, including breath tests, saliva, hair and urine tests. Each of these testing methods has varying strengths and weaknesses. Typically, breath and urine tests are the most regularly applied testing methods in workplace settings.

Workplace drug testing is a two-stage process involving an initial on-site screen using a point of collection test device, followed by a confirmatory laboratory analysis - to assess (confirm) the accuracy of any initial on-site positive result. The reason for this is that onsite point of collection tests are usually much less accurate and reliable than laboratory testing and all positive onsite screens need to be confirmed by subsequent laboratory analysis (as required by current Australian standards).

AOD testing in the workplace

There are typically four circumstances which occasion AOD testing in workplace contexts; pre-employment tests, which are undertaken prior to an individual commencing employment; random testing; for cause or targeted, which results from the employer having reason to believe that the employee may be using drugs; and following or not following an incident such as a workplace accident (Pidd et al 2011:40). It is evident that these four circumstances under which workplace drug

testing takes place will have varying effects on employee behaviour, for instance, there may be a reluctance to report workplace incidents if mandatory AOD testing ensues.

What works in reducing workplace hazards and harm?

It is important to preface this section with the assertion that there are a wide range of factors which contribute to workplace related hazards and harms, a number of which are cited to carry more grave consequences than AOD use in the workplace. Pidd et al (2011:4) notes that these include, but are not limited to, dangerous working conditions, conflict, poorly maintained equipment and insufficient training. Furthermore, it should be noted that there are significant limitations in the evidence regarding the efficacy of AOD testing in the workplace to reduce workplace related harms (Pidd et al 2011:75). These limitations are evident when examining workplace accidents, injuries and fatalities (Pidd and Roche 2011:12-4). VAADA is supportive of policies which are evidence informed and embrace a range of strategies to alleviate the likelihood of workplace related harm. Such strategies are likely to include AOD testing in some circumstances and should account for those populations most at risk of harm. Evidence demonstrates that men are more likely than women to suffer a work related fatality (McNeilly, Ibrahim, Bugeja and Ozanne-Smith 2010:424) with transport, postal and warehousing, as well as the agricultural and fishing industries reporting the highest levels of fatalities, although other industries, including hospitality, reported the highest levels of AOD use (McNeilly et al 2010:427).Targeting the safety specific positions in high risk industries is preferable than implementing such a policy across all industries.

Some studies indicate that education and training programs have a similar deterrent value as AOD testing (Pidd et al 2011:43).

In order for AOD testing to be effective, it should have the support of employees. Pidd et al (2011:77-8) indicate that employees are more likely to support an AOD testing program which emphasises treatment and counselling rather than punitive measures, is targeted towards industries which have a higher level of risk, allows for employee input, provides the opportunity to appeal, is clear on program intent and maintains a sound and credible evidence base.

Complexities in measuring the efficacy of AOD testing in the workplace

It would be erroneous to assume that a positive AOD test is indicative of impairment, given that some testing techniques may detect the presence of substances in the sample but provide limited or no information about when the substance was consumed or the level of impairment. Moreover, there are various means that those being tested may use to conceal AOD use, such as using substances which have a limited window of detection (displacement) or workplace absenteeism as a way to avoid the test (therefore creating additional expense and not alleviating the individual harms). Displacement could result in individuals taking more harmful substances which result in greater impairment, but which are less discernible to AOD screening. Testing may detect legal pharmaceuticals which have been prescribed (therefore necessitating the worker to disclose their private medical history), or it may produce a false positive (erroneously detecting the presence of substances) or a false negative (erroneously failing to detect the presence of substances) as most studies have indicated that even with the more advance laboratory AOD testing, there is scope for error (Pidd and Roche 2011:22).

Further to this is the confusion which can occur regarding the overall aim of testing. Broadly the purpose of testing relates to reducing risks in the workplace, but, in low risk workplaces the aim of AOD testing may be to achieve higher levels of efficiency, staff member health or it may be seen as responding appropriately to OH&S concerns. It would be concerning if an employer relied solely on AOD testing to alleviate AOD and related health and OH&S concerns. For instance, McNeilly et al (2010:423-4) on their study of coronial data into workplace deaths note that alcohol and other drugs were evident in 79 of the 355 workplace deaths which occurred between 2001-06 (roughly 20 per cent) but is estimated to have contributed directly in only 3 per cent of workplace fatalities. Such a finding, while not supporting workplace AOD use, indicates that AOD use in the workplace does not always conclusively equate to significant levels of risk.

As noted earlier, AOD testing may result in employees using substances which are less discernible, not reporting incidents and may contribute to a breakdown in their relationship with their employers, all of which will contribute to adverse workplace outcomes.

Logistical challenges for AOD testing in the workplace

With the exception of specific legislation relating to a small number of specific fields, such as aviation, Australia has no generic legislation or binding regulations which address workplace AOD testing. If such legislation was enacted, or mandatory guidelines developed, any broad ranging AOD testing scheme would experience a greater level of consistency, leading to clear aims and principles determining best practice which would be accessible to employers and employees and would be grounded in evidence. This would also articulate other logistical challenges and determine the means of addressing these issues. Regarding this point, VAADA is calling for consistency in standards for AOD workplace testing and not advocating for the implementation of AOD workplace testing across all industries. Its application should be considered on an industry by industry basis, with reference to the evidence including risk of harm, prevalence of use and with consideration of other workplace hazards which contribute to harm.

Further challenges in implementing workplace testing are evident in the expense and time lost through AOD testing. Each test will incur a cost to the workplace in both employee hours and sample examination expenses. Pidd et al (2011:49) cite a 2008 US study whereby only one person out of 2329 tested positive over an eight year period costing the workplace $93,160. This is an example of a significant fiscal outlay with minute positive detection rates, and does little to clarify the efficacy of AOD workplace testing in deterring AOD misuse. Thus, this result could be deemed a success citing the positive impact of deterrence, or may be an example of displacement or that this specific employee pool may not be regular AOD users. Such evidence requires further examination to eliminate such confounders and provide meaning to the data.

Testing which occurs after an incident could be problematic, as it may be necessary that such testing occurs within an emergency department at a hospital adding an extra duty to already overburdened emergency staff and may have ethical implications for staff when not mandated by law.

If an employee tests positive for AOD, how should the organisation respond? In some cases, they may terminate employment, which can have a devastating impact on the individual and their family, and may create difficulties in obtaining further employment. If one reflects on the loss of salary this makes for a very hefty penalty, particularly when this relates to recreational AOD use, outside of work hours, which has no or minimal impairment to worker function. Making treatment mandatory may be excessive, as an individual may be quite functional whilst engaging in substance use and may

not feel they require treatment. If such an approach were mandatory, it would consume significant resources unnecessarily. However, there will be some cases where individuals are using AOD in a harmful manner both with respect to the workplace and the individual. In such cases, AOD treatment services (who should not be administering any AOD testing) have a significant role in assessing and providing treatment and thus must be adequately resourced to ensure that they can meet the potential increase in demand resulting from AOD workplace testing. It should be noted that currently most AOD services cater to individuals who have chronic or severe AOD problems, not occasional users who are non-chronic consumers. However, AOD workplace testing may identify substance dependence issues with some employees, and with a number of industry lead AOD treatment services currently catering for specific industry populations, services such as Incolink (Construction Industry) and the Nursing and Midwifery Program (Victoria) should be adequately resourced to cater for the ramifications of AOD workplace testing.

AOD workplace testing may create an environment of distrust between staff members and management which can result in deterioration in workplace safety as well as an adverse impact on productivity. Further, privacy violations may emerge, as aspects of the employees personal life may be unnecessarily drawn into the workplace.

Conclusion

VAADA is committed to the application of evidence based policies. While workplace AOD testing may have a role to play in reducing the harms within the workplace and workforce, VAADA maintains reservations regarding its efficacy. We would be particularly concerned if it is deemed as the only way of dealing with AOD harms and workplace hazards. VAADA recommends that if AOD workplace testing is to be widely implemented, that it be enshrined in the appropriate legislation or regulations and that further research, and pilot programs, be undertaken prior to any significant roll-out of policy. Consideration must be given to the cost of AOD workplace testing versus the risk of harm which will vary across workplaces and workforces throughout Australia. In relation to this, we are of the belief that schemes and structures developed in consultation with the workforce, offer a much better route to achieving positive outcomes for all as compared to those that are simply imposed from above. We also consider that thought should be given to the appropriate level of response if a positive result occurs; such a response should not be punitive or rigid in nature, but rather emphasise health, safety and reducing harm, and provide a range of steps seeking to ameliorate the circumstances.

In some instances, AOD testing in the workplace may be a useful addition to a suite of other policies and practices related to workplace safety (such as education and training), yet it may be inappropriate for other low risk workforces. If changes are sought they should be informed by evidence, research and trial programs.

VAADA's Recommendations

VAADA recommends that:

1. Current evidence does not support the need for, or the effectiveness of, widespread workplace AOD testing as the primary means of minimising any potential workplace AOD related harm.
2. Workplace AOD testing may be appropriate in some high risk workplaces where impairment can have severe consequences.
3. The evidence base for AOD testing in the workplace should be enhanced with further research (or an evaluated pilot) determining efficacy prior to any further implementation or legislative consideration.
    - This research or pilot should account for the logistical challenges and possible perverse outcomes evident with AOD workplace testing;
4. Government, in consultation with stakeholders, should develop a binding set of standards to ensure consistency in AOD workplace testing policy and procedure, including appeal processes;
5. The AOD treatment sector is provided with the resources to ensure that it can support the employees and employers in cases where there are positive results; and
6. In the case that AOD workplace testing is more broadly rolled out, it is regularly reviewed and all data relating to testing is made publicly available.

References

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Disclaimer

While efforts have been made to incorporate and represent the views of our member agencies, the position and recommendations presented in this Paper are those of VAADA.